AUTHORIZED FOR LOCAL REPRODUCTION

# MEDICAL RECORD — CONSULTATION SHEET

## REQUEST

| TO: | FROM: *(Requesting physician or activity)* | DATE OF REQUEST |
|---|---|---|
| OPTOMETRY CLINIC M,T,W, F 0730-0900 | PHYSICAL EXAMS | |

REASON FOR REQUEST *(Complaints and findings)*

SM WHO ARE 40+ NEEDING IOP AND VISUAL FOR PHYSICAL

PROVISIONAL DIAGNOSIS

PHYSICAL EXAM

| DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION | |
|---|---|---|---|
| | | ☐ BEDSIDE ☐ ON CALL | ☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY |

## CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO  PATIENT EXAMINED ☐ YES ☐ NO  TELEMEDICINE ☐ YES ☐ NO

IOP

R:_____

L:_____  BY NCT/ APPLANTION

VISUAL ACUITY

| | | | | |
|---|---|---|---|---|
| UNCORRECTED: | DISTANT | R: 20/___ | CORRECTED: | R: 20/___ |
| | | L: 20/___ | | L: 20/___ |
| | NEAR | R: 20/___ | | R: 20/___ |
| | | L: 20/___ | | L: 20/___ |

*(Continue on reverse side)*

| SIGNATURE AND TITLE | DATE |
|---|---|
| | |

| HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT |
|---|---|---|
| | | |

| RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)* |
|---|---|---|
| | | |

| PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

**CONSULTATION SHEET**
Medical Record

**STANDARD FORM 513** (REV. 4-98)
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